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Advanced Beneficiary Notice (ABN) for Televisits

- Since the emergency COVID-19 pandemic declaration has ended, insurance companies may not pay for some televisits.
- Insurance is more likely to deny televisit appointment coverage for patients performing **televisits from a state outside Illinois** and for **first-time new patient televisit appointments**.
- We apologize that we are not able to verify coverage amounts for your specific policy prior to your visit.
- If you choose to schedule a televisit, you are responsible for billed amounts that are not covered by insurance OR that are covered but a balance is applied to your deductible expense policy.

To help you make an informed decision about your care and services provided, please read this notice, and ask any questions prior to choosing one of the options listed below:

Description of common televisit codes and charges (estimated cost usually reduced by insurance adjustments):

- **New patient televisits are charged based on time and/or complexity of the visit:**
  - Procedure code **99203**, charge billed to insurance $200
  - Procedure code **99204**, charge billed to insurance $305
  - Procedure code **99205**, charge billed to insurance $400
  - The charge is typically reduced by insurance when they "adjust" it to their contracted payment.
- **Established patient televisits are charged based on time and/or complexity of the visit:**
  - Procedure code **99213**, charge billed to insurance $147
  - Procedure code **99214**, charge billed to insurance $208
  - Procedure code **99215**, charge billed to insurance $291
  - The charge is typically reduced by insurance when they "adjust" it to their contracted payment.

You have the option, before providing consent, to verify with your insurance if a procedure code (also called an "E/M" code) is covered by your insurance plan. Refer to billing codes listed above.

Please initial or select ONE option:

____ 1. I consent to the televisit charge. Bill my health insurance plan.

____ 2. I consent to the televisit charge. Do not bill my health insurance plan. I prefer to be billed directly.

____ 3. I will not schedule a televisit and do not want to be billed for this service.

By signing below, if you selected option 1 or 2 above, you agree to take financial responsibility for payment for the televisit balance not covered by insurance.

Patient Name: _____ Date of Birth: _____

Patient or Responsible Party Signature: _____ Date: _____